LabCorp
Laboratory Corporation of America

Clinical Questionnaire for SNP Microarray

This form should be completed when SNP-based chromosome microarray testing is ordered (tests 510002, 052300, or 510508). The form should be completed by the ordering physician's office and should accompany the specimen. Please call 800-345-4363 with any questions and ask to speak to a cytogenetics genetic counselor.

Patient's name: _____

Date of birth: _____ Gender: _____ M _____ F

Name of person completing form: _____

Physician's signature: _____ Physician's phone number: _____
Physician signature is requires on printed from

Primary Diagnosis: _____ Primary Diagnosis (any delays): _____

Cognitive: _____

Suspect autism spectrum disorder? _____

Motor (gross) _____ (fine motor) _____

Growth (delays/overgrowth, etc): _____

Other: _____

Any dysmorphic features (unusual facial characteristics): _____

Review of systems (please comment on any issues/problems/abnormal studies associated with each system:

Neurological/Mental: _____ Chest/Lungs: _____

Heart: _____ Genito/Urinary: _____

Eye/Skin: _____ Other: _____

Any significant prenatal history: _____

Abnormal labs: _____

Chromosome analysis results: _____ Year performed: _____

Any significant family history: _____

Siblings: _____

Mother: _____ Maternal relatives: _____

Father: _____ Paternal relatives: _____

Are the parents related (other than by marriage, eg, first or second cousins), if so how:

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